Applicant No_____
Amt & Receipt #_____
Date Rec'd_____Date Issued_____

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

BOARD OF PHARMACY

APPLICATION FOR REGISTRATION OF INTERNSHIP FOR FOREIGN PHARMACY GRADUATE

The applicant for registration must have graduated from a foreign pharmacy school and received the first professional undergraduate degree from a pharmacy degree program which has been approved by the Board, and passed an equivalence exam recognized by the Board. Certification by the National Association of Boards of Pharmacy Foundation (NABP) Foreign Pharmacy Graduate Examination Committee (FPGEC) meets the equivalency examination requirements.

This application must be accompanied with a non-refundable processing fee. Please refer to the Fee Schedule at www.dpr.delaware.gov for the correct fee.

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1. Name of Applicant_____ Social Security Number_____

2. Phone_____Email_____

3. Address (Street and Number)_____

4. City, State and Zip_____

5. Date and place of birth_____

6. Name of Pharmacy School Attended_____

7. Date of Graduation_____

8. Date of Foreign Pharmacy Graduate Equivalency Certification_____
(Attach a copy of Foreign Pharmacy Graduate Equivalency Certificate)

9. Name of Preceptor_____Phone_____

10. Address (Street and Number)_____

11. City, State and Zip_____

12. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? Yes____ No____ **If yes, submit a certified copy of your criminal history record.**

Please note: When your application is <u>complete</u>, please allow 4-8 weeks to receive your license. A <u>complete</u> application is one that includes all required documentation and correct payment.

Applications that are not <u>complete</u> within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

I swear or affirm that the information contained in this application are true and correct.

_____
Signature of Applicant

NOTE: Pharmacy Intern must notify the Board of Pharmacy within ten days and in writing of change of preceptor

STATE OF _____

ss.

County_____

(Sign here)_____(SEAL)

Subscribed and sworn to before me this ___day of _____ A.D. _____
Witness my hand and seal hereunto attached.

(Notary signature)_____(SEAL)

AFFIDAVIT OF PRECEPTOR

I hereby certify that I accept the responsibility of a preceptor for the applicant whose name appears on this document. I agree to provide him/her with the experience outlined in the Board's Practical Experience Program. If I terminate my preceptorship agreement with the applicant, I will notify the Board in writing. I also hereby certify that I am a registered pharmacist and have been practicing for at least two years.

_____

Signature of Preceptor

Subscribed and sworn to before me

This_____day of_____, _____

_____SEAL)